What should the role of the dentist be in managing patients with eating disorders?

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Key points

- Estimated 1.25m people have an eating disorder in the UK
- Over-stretched profession?
- Could increase in 'holistic' approach of the dental team help these patients?

Introduction

Back in 2016 I returned to my old university to interview then Executive Dean of the College of Clinical and Biomedical Sciences at the University of Central Lancashire, StJohn Crean. During the interview he spoke about the future, which for him included creating a college of 'One Health' – people working together who emerge with different skills but with one focus – the patient.

Perhaps there's another application of the vision that applies to the role of the dental professional. After all, there's encouragement to ask patients about their diet, alcohol intake and smoking status, specifically with oral cancer in mind. These are easy discussions to have. There's a different group of conversations that the dental professional could/should have (delete as appropriate according to your own thoughts) that are far more difficult to broach, and they're surrounding the wider welfare of the patient.

When we talk about safeguarding, our brains almost always think about children. It's the parental instinct to protect that kicks in – quite right too. We do so because they're vulnerable and yet we don't always immediately think of those who are vulnerable when it comes to safeguarding. In this very issue there's an article about dentists and gender based violence,[1] which firmly falls into the category of difficult conversations. Dental professionals are also encouraged to discuss that other oral cancer risk factor – HPV – which means talking to patients about oral sex. In conversation with some friends in the profession, their reaction to this has very much been along the lines of 'critical high yikes' – no way, even though they know they should. Others simply aren't sure where or how to begin, which is a very different starting point. For me, there's one more addition to the 'difficult conversation' column that also directly affects the oral health of a patient; eating disorders.

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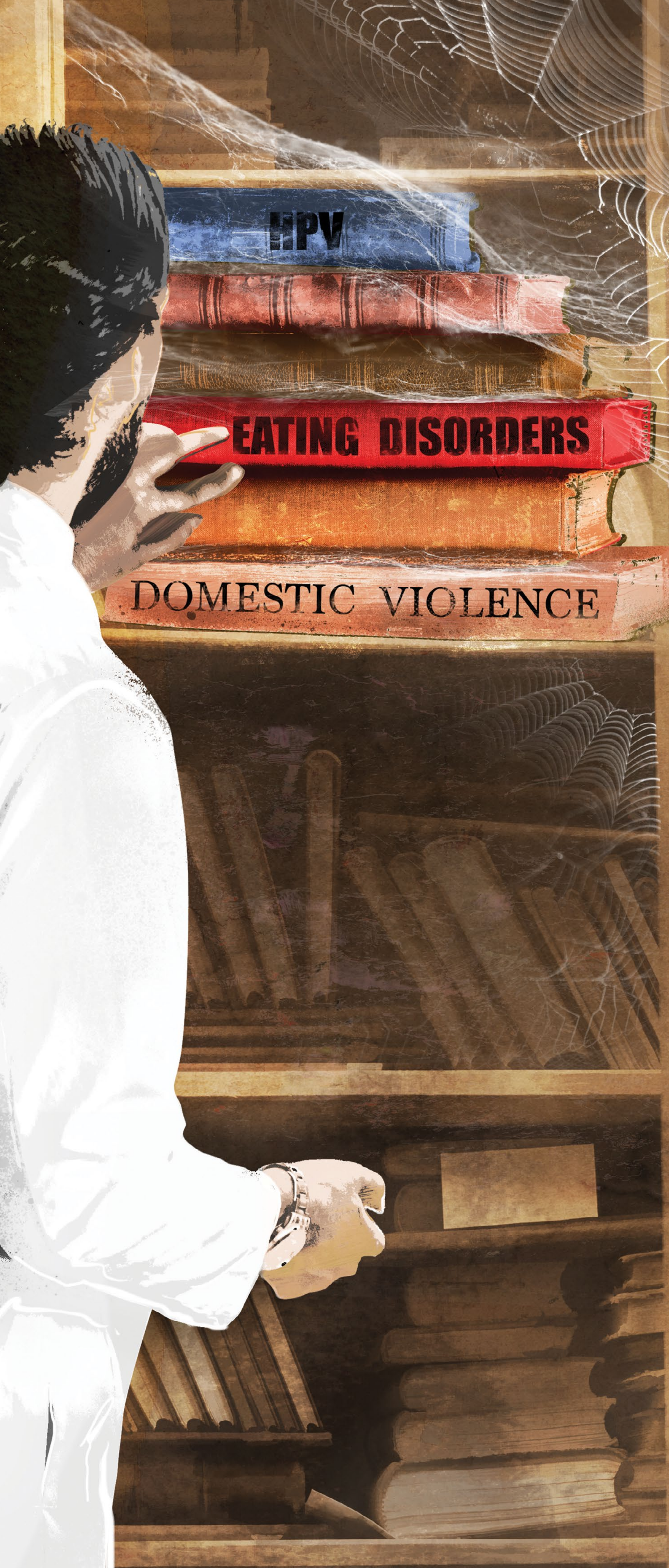

The under-reported and the unknown

According to Beat, around 1.25 million people in the UK suffer from these illnesses, many in secret.[2] They are of all ages, genders and backgrounds – eating disorders do not discriminate. Eating disorders include bulimia, binge eating disorder, avoidant/restrictive food intake disorder (ARFID), other specified feeding or eating disorder (OSFED), and anorexia, which tragically has the highest mortality rate of any mental illness, though all eating disorders can be deadly. While this is the worst-case scenario, the charity says there are many ways in which eating disorders severely affect the quality of life of both those suffering and those who care about them. People with eating disorders have often been characterised as vain young women obsessed with their appearance. But that's a dangerous stereotype, as anorexia nervosa and bulimia nervosa affect males and females across every demographic, often as the result of complicated psychological causes.

They also point to the fact there has not been sufficient research to draw firm conclusions about the prevalence of eating disorders in the UK, so the true prevalence of eating disorders is largely unknown. Perhaps that is why in a search of *BDJ* research articles using the search term 'eating disorders' there are only four papers that *specifically* mention eating disorders. This made me think: is the under-reported and unknown nature of the prevalence directly responsible for the relative low priority eating disorders are given when discussing signs of the problem with patients?

In 2015, Linda Douglas, when writing for *BDJ Team*, wrote that while she was in an ideal position to detect oral signs of eating disorders, her knowledge of those signs was limited and, more to the point, she wasn't alone.[3] She cited research that highlighted dentists and dental hygienists randomly selected from the American Dental Association and the American Dental Hygienists' Association recorded low scores concerning knowledge of oral cues, physical cues of anorexia, and physical cues of bulimia among study participants.[4] Besides the oral manifestation, what about the physical manifestation? In a world pre-COVID-19, the dentist would be the one regular touchpoint within the healthcare industry. They would perhaps be able to match up answers about diet to physical appearance and oral signs – has the patient lost weight, and why am I seeing increased signs, those of which are listed in Box 1? Would they know to join the dots, and if so, would they then be

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bold enough to discuss it? There is no denying that this profession has prime real estate when it comes to identifying some ailments – alcohol and substance abuse, tobacco use, signs of dementia and even diabetes. Why would these issues be 'easier' to approach than if signs of an eating disorder were presented?

It is not the role of the dentist to treat the eating disorder, but to signpost the patient to the appropriate help, to treat the oral condition and to be a safety net for patients who may need a safe space. Maybe a patient will not immediately seek help for fear of any repercussions and stigma attached. However, six months down the line and their oral health has deteriorated, the patient will go for treatment, thinking a dentist will not put two and two together. As a healthcare professional you soon get a grasp of whether a patient is giving you the full picture regarding their oral health routine. Knowing what to do and giving the right response from thereon in can make all the difference.

Overburdened?

Perhaps dentistry took its time to realise its role as a wider bastion of healthcare, the alternative definition of 'one health'. Perhaps with the new generation of dental professionals coming through who have a greater concept of a wider social responsibility, we will see the profession doing more. Until then, dentistry will continue to act as a safety net for those who fall through it – both from other healthcare areas, and from itself. But is that realistic in today's climate?

At the time of writing, and with less than one week to go, the British Dental Association has accused authorities of treating NHS dentists across England with disrespect following a failure to provide clarity on the NHS contractual arrangements set to commence on Friday 1 October. Funding for NHS high street dentists has been subject to imposed activity targets from 1 January 2021, which obliged contract holders to hit a threshold of 45% of pre-COVID activity or face financial penalties. This target rose to 60% from 1 April. At every step dentists have been given last minute notification to prepare for radical changes in their working model.

This approach has been widely criticised as setting perverse incentives to prioritise routine over urgent care – or 'volume over need' – with a large proportion of practices still struggling to hit targets in the face of COVID-19 restrictions. The BDA has underlined this approach was wholly at odds with comments from the Prime Minister made just last week, when he stressed 'we want the NHS to be a better place for the dental profession'.

While contractual arrangements for NHS practitioners seems at odds with discussing eating disorders, the very landscape of in-practice dentistry is vastly different to anything that has gone before it. Faced with ongoing uncertainty over targets, high levels of PPE and backlogs that some believe will take significant time and major overhaul to clear, the dynamic between patient and practitioner has changed. Communication while wearing personal protective equipment (PPE) is a challenge. Information being communicated between patients and their dentists is important to understanding the dentition they are seeing, that is now a diminished reality. This recollection from an American colleague suggests it remains possible if you know what you look for.

'It was a typical busy day—three hygiene exams, a crown patient in one chair, and two other patients needing a moment of my time.

'But that all stopped when I did an exam on a patient whom I initially thought was a healthy 27-year-old woman with notable erosive lesions on the lingual aspect of her maxillary teeth. First thing I thought, 'this isn't normal at all'.

'It was clear, due to the pattern of wear, that this patient had a history of bulimia but wasn't aware of the oral manifestations that had resulted from her binge-and-purge habits. My concern was evident (as was my curiosity), and I took a few private minutes to dive into a discussion about my findings – not my suspicion as to the diagnosis, but my findings.

'After some gentle probing, the patient embarrassingly confessed to her bulimia habit, which clearly wasn't an easy thing to do. Interestingly enough, I got the vibe that she needed or wanted to tell someone about what was going on in her life, and that window of opportunity presented itself by way of a dental visit.

'Managing the patient's dental condition was one thing; helping her toward recovery was another. I reassured her that her oral condition was manageable, but the *status quo* needed to change. I told her I would be happy to assist her in the process. I sensed relief and gratitude on her part. Sometimes, the starting point in the recovery process can be the hardest hurdle to overcome.'[6]

Would this scenario have taken place were high levels of PPE still needed? Perhaps it would. Clearly, masks make communication more difficult and create a psychological barrier to the development of a robust and professional therapeutic relationship that is crucial for the development of trust.

Box 1 Oral signs and symptoms that can indicate an eating disorder is present include:

- Enamel erosion and erosive lesions
- Severe erosion on lingual surfaces of the maxillary anterior teeth
- Moderate erosion on lingual and occlusal surfaces on upper molars
- Erosion on lingual and occlusal surfaces on lower posterior teeth
- Mucosal lesions and pharyngeal abrasion
- Weakening of incisal edges of incisor teeth
- Anterior open bite
- Loss of vertical dimension
- Bleeding gingiva
- Enlargement/swelling of salivary glands (especially parotid glands) or other swelling in cheeks/jaw
- Difficulty swallowing (i.e. lump in throat, globus sensation)
- Changes in colour, shape and length of teeth or teeth that are brittle, translucent and weak
- Moderate to high thermal sensitivity in teeth/gums
- Pulp exposure or pulp death
- Reports of frequent sore throats or dry mouth, burning tongue
- Dry, red or cracked lips All of these may be signs or symptoms of disordered eating behaviour, including restrictive eating, frequent purging and starvation.[5]

Without that trust, it is unlikely a patient would feel comfortable opening up – if asked or encouraged to do so – about an eating disorder. Dentistry requires a degree of collaboration and understanding – any barrier to communication in the dental setting will diminish the level of rapport and increase the potential for patient dissatisfaction. A study of over 1,000 patients randomised to mask-wearing and non-mask-wearing physicians revealed a significant and negative effect on patient perception of physician empathy in consultations performed by mask-wearing physicians.[7] Whichever way you cut it up, a new approach has been forced upon the profession who are expected to perform in the same way they did before COVID-19 happened.

Integrating a holistic approach

'Put the mouth back in the body' was a phrase I heard more times than my own

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name in late 2015 and early 2016, a timespan that coincided with the appointment of Chief Dental Officer England, Sara Hurley. As well as being an easily identifiable goal, the implications were multi-factorial and centred around the need for the dental community to step out of the silo it operated in and integrated into the wider healthcare world. Why did dentists not speak to GPs and *vice versa*? In 2017, Nairn Wilson wrote:

'Why do dentistry and oral health provision continue to be poor relatives in general healthcare and wellbeing considerations? Is it a result of ingrained perceptions among medical colleagues,[3] especially those who determine healthcare policy, inadequate future proofing of educational guidance for programmes of dental studies, or a failure of the dental profession to press for arrangements which will allow dentistry to realise its potential in forward looking, value-based, preventatively-orientated, minimal intervention, patient-centred care? A further possible cause is money, given that new funding would be required to get dentistry from where it is presently to where it should be positioned in the big healthcare picture, with the prospects of substantial medium to long-term efficiency savings. Sadly, it is suggested that oral healthcare remains largely contained in a 'dental silo' for all these reasons, to a greater or lesser extent – a Gordian knot, or a golden opportunity for a high-level, innovative change of direction in the best interests of patients. Everything points to a golden opportunity, with good prospects of future cost-containment and associated knock on benefits; for example, retention of the exceptional talent which continues to be attracted to a career in dentistry.

If you are not yet convinced of the need to sign up to interprofessional, holistic healthcare, with dentistry in the thick of the arrangements, then consider the challenges of 'teeth for life' and the provision of lifelong oral healthcare. As concluded at a United Nations 'high-level' meeting, to address these challenges, oral healthcare (dentistry) must be integrated into a 'healthy-life approach', requiring a transformation of health systems, coordinated at different levels of government and regulation. While the way forward is clear, some would say incontrovertible, and it is widely accepted that failure to take early action of the type suggested in the face of growth in high-health-cost elderly populations will severely stress already hard-pressed health systems, there would appear to be a lot of heads in the sand, or people with their hands tied, real or perceived, for one reason or another. Time to face up to the need for action, difficult as it may be, and for those with the power and authority to act or be given a mandate to effect transformational change.'[8]

The very principles of a holistic approach would fundamentally make the management of patients with eating disorders easier. While some still associate a holistic approach with alternate medicine and complementary therapies, applied to dentistry its meaning is different. And yet, that approach requires time, something the ongoing restrictions do not allow for.

The impact of this cannot be understated. according to a survey of dentists in England, 47% indicated they were likely to change career or seek early retirement in the next 12 months should current COVID-19 restrictions remain in place. The same proportion say they are likely to reduce their NHS commitment as well.

Also, working in high-level PPE mandated under current infection control procedures is having a devastating effect, the BDA said, with 88% indicating it is having a high impact on their morale.

Additionally, 78% say financial uncertainty is also having a high impact on their ability to provide pre-pandemic levels of care. Two-thirds cite hitting NHS targets imposed by the government on January 1, 2021. Since the new year, the BDA said, the workforce has reported the highest levels of stress compared to any point since the onset of the pandemic. Nearly two-thirds of NHS dentists estimate they won't meet imposed targets and will face penalties for not hitting 60% of their pre-pandemic activity levels. Those that have made progress say that they have done so unsustainably.

Meanwhile, 62% say their practice had to invest in new ventilation equipment without any government support, 41% say they were forced to refocus on routine over urgent appointments, and similar numbers say they have reduced private work or reduced or eliminated annual leave. While securing new equipment has been the number one strategy deployed by dentists to meet NHS activity targets, the BDA said, nearly 70% of practices say they now face financial barriers to further investment.

Finally, the BDA said, 47% of dentists lack confidence in terms of the business outlook for their practice should current standard operating procedures remain unchanged.

The BDA's analysis of Freedom of Information data indicates that nearly 70% of appointments, or 28 million courses of treatment, that would have been delivered in NHS services in England in the year since March 2020 have been missed. The BDA estimates the figure to have grown to exceed 30 million.

Low morale. Stress. Financial uncertainty. Ongoing PPE requirements. Missed appointments. All items that have the potential to impact the provision of holistic dental care. Over the past year, child and adolescent eating disorder services of the NHS have seen almost a doubling in the number of both urgent and routine referrals,[9] creating a further issue for the dentists of today and tomorrow to address.

Perhaps the alternate vision of Crean's 'One Health' and CDO Hurley's desire for putting the mouth back in the body will one day materialise. Perhaps one day patients presenting with a problem not strictly associated with their oral health but which impacts it, will not take dental professionals by surprise. Perhaps neither of these things will come to fruition, and in the meantime, more will be asked of dental professionals to join their own dots. They have to. For the sake of the patient. ◆

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